CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

APPLICATION FOR VOLUNTEER LICENSE TO PRACTICE MEDICINE AND SURGERY
INSTRUCTION SHEET

Please read all instructions carefully before completing and submitting your application. Failing to follow instructions may delay your licensure. Auxiliary forms you need are included in this packet.

Checklist for *All* Applicants

☐ Submit completed, signed and notarized application form.
- Make sure all questions are answered unless the instructions tell you to skip a question.
- Read the AFFIDAVIT section.
- Sign the application in front of a notary public.

☐ If you answer "yes" to Questions 17 – 27 in the DISCLOSURES section, you must fully explain your answer. It is suggested that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*.

☐ Complete the *Criminal History Record Check Authorization* form to request state and federal criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Arrange for the Board office to receive a *Recommendation from Chief of Staff or Chief of Service* form mailed *directly* from the Chief of Staff or Chief of Service in a medical facility where you currently or previously had privileges.
- The hospital/medical facility's institutional seal must be affixed to the form. If no seal is available, the completed form must be notarized.
- Faxed forms will not be accepted.

☐ If you now hold, or have *ever* held, a medical or training license in any jurisdiction other than Delaware, arrange for the Board office to receive a *Verification of Physician License* form from *each* jurisdiction where you have held a license.
- Before forwarding the form, check whether the jurisdiction requires a fee.
- The Board office must receive the completed verification *directly* from the other jurisdiction. The jurisdiction's seal must be affixed to the form.
- Internet verifications or faxed verifications will not be accepted.

☐ Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the ***original report*** to the Board office.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
- *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

Additional Requirement for *FCVS Applicants*

Delaware accepts the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards (FSMB). For more information, see the FCVS website at www.fsmb.org/fcvs_physician.html.

☐ If you use the FCVS service, arrange for the Board office to receive your Physician Information Profile.

Additional Requirements *Non-FCVS Applicants*

If you are not using the FCVS service, the following requirements apply.

☐ Submit an 8 1/2" X 11" copy of your medical school diploma.
- If you are a foreign medical graduate, attach an English translation from a reputable translating organization.

☐ Arrange for the Board office to receive a *Verification of Medical Education* form from *each* medical school that you attended.
- The Board office must receive the completed form *directly* from each school. The school's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ If you graduated from a foreign medical school, submit 8 1/2" X 11" copy of your current and valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate.

☐ Submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s).
- Only training programs are those that have been approved by the Accreditation Council for Graduate Medical Education will be accepted.
- If you graduated from a program approved by the American Medical Association (AMA) or American Osteopathic Association (AOA) in the U.S. (or U.S. territory) or Canada, you must have completed one year of postgraduate training in the U.S.
- If you did not graduate from an AMA- or AOA-approved program, you must have completed three years of postgraduate training in the U.S.

☐ Arrange for the Board office to receive a *Verification of Post Graduate Medical Education* form from *each* program that you attended.
- The Board office must receive the completed verification *directly* from each program. The program's seal must be affixed to the form. If no seal is available, the form must be notarized.
- Internet verifications or faxed verifications will not be accepted.

☐ Request a complete examination history, including all passing and failing attempts, sent *directly* to the Board office from the following organizations:

- ECFMG – Request report at www.ecfmg.org.
- Federal Licensing Examination (FLEX), United States Medical Licensing Examination (USMLE), and Special Purpose Examination (SPEX) examinations administered by the Federation of State Medical Boards – Request report at www.fsmb.org.
- National Board of Medical Examiners (NBME) examination administered by the National Board of Medical Examiners – Request report at www.nbme.org.
- National Board of Osteopathic Medical Examiners (NBOME) Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examinations administered by the National Board of Osteopathic Medical Examiners. Request report at www.nbome.org
- Qualifying Examination (QE) Part I and Part II conducted by the Medical Council of Canada for the purpose of awarding the "Licentiate of the Medical Council of Canada" (LMCC). Request report at www.mcc.ca.

Personal Interview

A personal interview with a member of the Board is required for all Physician applicants. When your application has been reviewed, the Board office will notify you whom to contact to schedule your interview.

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APPLICATION FOR VOLUNTEER LICENSE TO PRACTICE MEDICINE AND SURGERY

TYPE OF APPLICATION

1. I am applying for Volunteer Physician licensure as a:

   ☐ MD – I received my medical education: ☐ in the U.S. ☐ outside the U.S.
   ☐ DO

2. Will you use the FCVS to provide your Physician Information Profile to the Board? Yes ☐ No ☐

IDENTIFYING AND CONTACT INFORMATION

3. Full Name: _____ _____ _____
   Last First Middle

4. Other Names Used: _____

5. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

6. Do you have a U.S. Social Security Number? Yes ☐ No ☐ If yes, enter SSN: _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

7. Mailing Address: _____

   _____ _____ _____
   City State Zip

8. Phone: _____ _____ 9. Email: _____
   Home Work

MEDICAL EDUCATION

10. Enter complete information about your medical education.

SCHOOL NAME	LOCATION	DATES ATTENDED	DEGREE RECEIVED

If you are not using FCVS, submit an 8 1/2" X 11" copy of your medical school diploma and arrange for the Board office to receive a *Verification of Medical Education* form from each medical school.

11. Did you graduate from a foreign medical school? Yes ☐ No ☐ If yes, enter your USMLE/ECFMG Identification Number: 0- _____ **If you are not using FCVS, submit 8 1/2" X 11" copy of your ECFMG certificate.**

POST-GRADUATE TRAINING

12. Enter complete information about your post-graduate training.

HOSPITAL/INSTITUTION	LOCATION	DATES TRAINING	SPECIALTY

If you are <u>not</u> using FCVS, submit an 8 1/2" X 11" copy of your Postgraduate Education Training Certificate(s) and arrange for the Board office to receive *Verification of Post Graduate Medical Education* form from each program.

13. Enter the following information about your area/field of specialization.

AREA/FIELD	ARE YOU BOARD ELIGIBLE?	ARE YOU BOARD CERTIFIED?
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐

EXAMINATION HISTORY

14. Check each examination that you have taken and enter the requested information about that exam.

☐ ECFMG (Basic) If passed, date: _____
☐ ECFMG (Clinical) If passed, date: _____
☐ ECFMG (English) If passed, date: _____

☐ Flex Component 1 If passed, date: _____
☐ Flex Component 2 If passed, date: _____
☐ Pre-1985 Flex If passed, date: _____

☐ USMLE Step 1 If passed, date: _____
☐ USMLE Step 2 If passed, date: _____
☐ USMLE Step 3 If passed, date: _____

☐ NBME Part 1 If passed, date: _____
☐ NBME Part 2 If passed, date: _____
☐ NBME Part 3 If passed, date: _____

☐ NBOME Part 1 If passed, date: _____
☐ NBOME Part 2 If passed, date: _____
☐ NBOME Part 3 If passed, date: _____

☐ SPEX If passed, date: _____

☐ COMLEX Level 1 If passed, date: _____
☐ COMLEX Level 2 If passed, date: _____
☐ COMLEX Level 3 If passed, date: _____

☐ LMCC If passed, date: _____
☐ State Board Examination State: _____ If passed, date: _____

If you are <u>not</u> using FCVS, arrange for Board office to receive complete examination histories, including all passing and failing attempts, from the organization.

LICENSURE HISTORY

15. List *each* state or U.S. territory where you now hold, or have *ever* held, a medical license, including training licenses.

STATE/TERRITORY	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

Arrange for the Board office to receive a *Verification of Physician License* form from each jurisdiction where you have held a license. This applies whether or not you are using FCVS.

DISCLOSURES

If you answer "yes" to Questions 17 – 27 in this section, you must fully explain your answer. It is suggested that you use the *Physician Self-Report* form for this purpose. However, if the *Physician Self-Report* does not fully cover your situation, you may submit a signed, notarized statement in lieu of or in addition the *Physician Self-Report*. The statement should specify the state where the incident occurred, the issues involved and any further information you wish to provide.

16. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐

    Arrange for the Board office to receive state and federal criminal background checks. This applies whether or not you are using FCVS.

17. Have you ever been professionally penalized or convicted of fraud? Yes ☐ No ☐

18. Have you ever had a medical or professional license denied or revoked? Yes ☐ No ☐

19. Have you ever violated the Medical Practice Act of another state? Yes ☐ No ☐

20. Have you ever been disciplined or had formal written action taken by a hospital staff or medical society, or licensing board of another state? Your response should include any discipline or action taken during your training program including, but not limited to, academic probation. Yes ☐ No ☐

    Request a self-query from the NPDB/HIPDB and submit the *original report* to the Board office. This applies whether or not you are using FCVS.

21. Has a hospital, related health care facility, HMO, or alternative health care system ever:
    - denied your application for privileges or failed to renew your privileges?
    - limited, restricted, suspended, or revoked your privileges in any way (including during your training program)? Yes ☐ No ☐

    Arrange for the Board office to receive a *Recommendation from Chief of Staff or Chief of Service* form mailed *directly* from the Chief of Staff or Chief of Service in a medical facility where you currently or previously had privileges. This applies whether or not you are using FCVS.

22. Have any charges or complaints of any kind, including malpractice claims, ever been filed against you? (Include any that are *currently* pending against you.) Yes ☐ No ☐

23. Have you ever engaged in the practice of medicine without a license? Yes ☐ No ☐

24. Have you ever willfully violated the confidence of a patient? Yes ☐ No ☐

25. Within the past five years, have you ever raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any:
    - administrative or judicial proceedings or investigation?
    - inquiry or other proceeding?
    - proposed termination by an educational institution, employer, governmental agency, professional organization, or licensing authority?

    Yes ☐ No ☐ If yes, continue with Question 27. If no, skip to Question 29.

27. Are such current conditions or impairments reduced or ameliorated because of ongoing treatment (with or without medication) or participation in a monitoring program or because of the field of practice, the setting, or the manner in which you have chosen to practice medicine? Yes ☐ No ☐

28. If you claim to have a mental or physical disability which limits your ability to practice medicine in a fully competent and professional manner with safety to patients, are you willing to accept a conditional or limited license to practice medicine if it is possible to accommodate such disability? Yes ☐ No ☐

29. Do you agree to submit to an examination at your own expense if the Executive Director of the Board of Medical Licensure and Discipline deems it necessary to determine whether your physical and/or mental impairment presents a significant risk to the health or safety of patients or otherwise causes you not to be fully qualified to practice medicine in a competent and professional manner with safety to patients without limitations or accommodations? Yes ☐ No ☐ If no, submit a signed notarized statement fully explaining your answer.

If your application requires Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six (6) months of filing may be considered abandoned and discarded.

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I swear that I am the person who executed this application, that the statements contained on this application are true in every respect, that I have not suppressed or withheld information that might affect this application, that I will abide by the laws and the ethical standards of this profession, and that I have read and understand this statement.

I hereby authorize and consent to have an investigation conducted to determine my professional qualifications, to determine whether I have previously engaged in unprofessional conduct as defined in 24 *Del. C.* §1731 or the Rules and Regulations of the Delaware Board of Medical Licensure and Discipline and to determine that I am physically and mentally capable of engaging in the practice of medicine with safety to the public.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution or other organization having control of any documents, records or other information pertaining to me, to furnish to the Delaware Board of Medical Licensure and Discipline any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or other pertinent data and to permit the Delaware Board of Medical Licensure and Discipline or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice thereunder.

I understand and acknowledge that the Delaware Board of Medical Licensure and Discipline will rely on the information I have provided in this application in making its determination on licensure. I hereby expressly agree to (1) keep the information I have provided in this application current until such time as the Board has finally acted on it, and (2) to promptly provide any and all additional information requested by or on behalf of the Board.

Signature of Applicant: _____ Date: _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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RECOMMENDATION FROM CHIEF OF STAFF OR CHIEF OF SERVICE

Arrange for the Board office to receive this form from the Chief of Staff or Chief of Service in a medical facility where the Physician applicant currently or previously had privileges.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.

Last Name:_____ First:_____ Middle: _____

SSN:_____ DOB:_____ Other Name(s) Used: _____

Applicant Signature: _____ Date: _____

Evaluation to be completed by Chief of Staff or Chief of Service

Complete all items.

Check your evaluation of each element. Base evaluation on your personal knowledge or records maintained by your hospital.

Element	Unable to Evaluate	Below Average	Average	Above Average
Basic Medical Knowledge	☐	☐	☐	☐
Professional Judgment	☐	☐	☐	☐
Sense of Responsibility	☐	☐	☐	☐
Clinical Skills	☐	☐	☐	☐
Technical Skills	☐	☐	☐	☐
Cooperativeness, Ability to Work with Others	☐	☐	☐	☐
Medical Record Currency	☐	☐	☐	☐
Quality of Medical Records	☐	☐	☐	☐
Patient Management	☐	☐	☐	☐
Physician – Patient Relationship	☐	☐	☐	☐
Overall Performance	☐	☐	☐	☐

If you responded "Unable to Evaluate" or "Below Average" on any item, explain why on a separate sheet.

Unusual Circumstances to be completed by Chief of Staff or Chief of Service

Complete all items.

1. Was this applicant ever placed on probation? Yes ☐ No ☐
2. Was this applicant ever disciplined or placed under investigation? Yes ☐ No ☐
3. Were any limitations or special restrictions placed on this applicant due to questions of academic incompetence, disciplinary problems or any other reason? Yes ☐ No ☐

Explain *yes* answers and any other unusual circumstances on a separate sheet.

CERTIFICATION

AFFIX

INSTITUTION

OR NOTARY

SEAL HERE

I am licensed in the State of _____. I have known the applicant personally or professionally for the period (month/year)_____ to (month/year) _____.

☐ I recommend this applicant for licensure to practice medicine and surgery without reservation.
☐ I recommend this applicant for licensure to practice medicine and surgery with reservation.
☐ I **do not recommend this applicant for licensure** or to practice medicine and surgery.

Print Name of Institution Official: _____ **Title:**_____

Signature of Official: _____ **Date:** _____

Phone: _____ **Fax:** _____ **Email:**_____

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**

Revised 7/2010

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VERIFICATION OF PHYSICIAN LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice medicine.

Licensing Authority:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ DOB:_____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ **I am applying for licensure as a Physician in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Medical Licensure and Discipline.** This includes any medical training licenses. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____ Has any discipline activity taken place regarding this licensee? Yes ☐ No ☐ **If yes, please enclose a certified copy of the Board Order with this license verification.**
CERTIFICATION **AFFIX** **OFFICIAL** **SEAL HERE**	**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.** **Printed Name of Official:** _____ **Signature of Official:** _____ **Date:** _____ **Title:**_____ **Phone:** _____ **Fax:** _____ **Email:**_____

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VERIFICATION OF MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to each medical school attended.

Educational Institution:_____	Applicant Name: _____
Address:_____	Home Address: _____
City/State/Zip: _____	City/State/Zip: _____

This section is to be completed by applicant.

Last Name:_____ First:_____ Middle: _____

SSN:_____ Birth Date:_____

Other Name(s) Used: _____

Applicant Signature: _____ Date: _____

This section to be completed by Institution.

1. Enter periods that the applicant named above was enrolled in institution:

YEAR	FROM (mm/dd/yyyy)	TO (mm/dd/yyyy)
1		
2		
3		
4		

2. Was the applicant awarded a degree? Yes ☐ No ☐
   - If yes, enter:
     Degree Received: _____ Date (mm/dd/yyyy) Degree Conferred: _____
   - If no, attach explanation of reason applicant did not receive a degree.

AFFIX INSTITUTION OR NOTARY SEAL HERE

I certify that the information above is an accurate account of the applicant's records and is true and correct.

Printed Name of Institution Official: _____

Signature of Official: _____ **Date:** _____

Title:_____

Phone: _____ **Fax:** _____ **Email:**_____

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VERIFICATION OF POST-GRADUATE MEDICAL EDUCATION

Physician applicants who are *not* using the FCVS service should send this form to each program attended.

Educational Institution: ______________________	Affiliated University: ______________________
Address: ______________________	Address: ______________________
City/State/Zip: ______________________	City/State/Zip: ______________________

This section is to be completed by applicant.	Last Name: ______________ First: ______________ Middle: ______________ SSN: ______________ DOB: ______________ Other Name(s) Used: ______________
Program Participation to be completed by Institution **Complete all items.**	• Use one section per department. If department is rotating or traditional, provide a schedule of rotations. • Report Internships, Residencies and Fellowships separately. • If the PGY is currently underway, report the expected completion date in the TO field. • Report incomplete PGY's separately from successfully completed PGY's.
	PGY Year: ______ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other
	Department: ______________________ From (mm/dd/yyyy): ______________ To (mm/dd/yyyy): ______________ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: ______________
	PGY Year: ______ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other
	Department: ______________________ From (mm/dd/yyyy): ______________ To (mm/dd/yyyy): ______________ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: ______________
	PGY Year: ______ ☐ Internship ☐ Residency ☐ Fellowship ☐ Research ☐ Other
	Department: ______________________ From (mm/dd/yyyy): ______________ To (mm/dd/yyyy): ______________ Successfully completed? Yes ☐ No ☐ In Progress ☐ Accreditation: ACGME ☐ AOA ☐ Not Accredited ☐ Other ☐ Explain: ______________
Unusual Circumstances to be completed by Institution **Complete all items.**	1. Did this applicant ever take a leave of absence or break from training? Yes ☐ No ☐ 2. Was this applicant ever placed on probation? Yes ☐ No ☐ 3. Was this applicant ever disciplined or placed under investigation? Yes ☐ No ☐ 4. Did the instructors file any negative reports on this applicant? Yes ☐ No ☐ 5. Were any limitations or special restrictions placed on this applicant because of questions of academic incompetence, disciplinary problems or any other reasons? Yes ☐ No ☐ **Explain *yes* answers and any other unusual circumstances on a separate sheet**.
CERTIFICATION **AFFIX INSTITUTION OR NOTARY SEAL HERE**	I certify that the information above is an accurate account of this individual's records and is true and correct. **Print Name of Program Director (MD or DO):** ______________________ **Signature of Program Director:** ______________________ **Date:** ______________ **Phone:** ______________ **Fax:** ______________ **Email:** ______________

***Mail* (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.**

Instructions for Requesting a Criminal Background Check

Both state and federal criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State and Federal criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.

2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned. Send the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

PLEASE PRINT OR TYPE ALL INFORMATION IN BLACK INK.

CHECK TYPE OF LICENSURE FOR WHICH APPLYING:

- ☐ Adult Entertainment
- ☐ Deadly Weapons Dealer
- ☐ Dental
- ☐ Medical
- ☐ Nursing
- ☐ Nursing Home Administrator
- ☐ Pharmacy
- ☐ Texas Hold'em Dealer
- ☐ Other _____

ENTER FULL CURRENT NAME:

_____ _____ _____ _____
Last Name | First Name | Middle Initial | Suffix (e.g., Jr., Sr.)

ENTER ALL OTHER NAMES USED IN THE PAST (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

AUTHORIZATION TO RELEASE INFORMATION

As an applicant, I authorize release of any and all information that you have concerning me, including **CRIMINAL HISTORY RECORD INFORMATION** and other information of a confidential or privileged nature. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date:** _____

Phone: Home _____ Work: _____

MAIL THE RESULTS OF MY CRIMINAL HISTORY REQUEST TO:

Division of Professional Regulations
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

PHYSICIAN SELF-REPORT FORM

The Physician's duty to self-report is in 24 Del C. § 1731A. To comply with your duty to report, complete and submit this form to the Board of Medical Licensure and Discipline within the required time limit. You may duplicate the form.

IDENTIFYING AND CONTACT INFORMATION

1. Physician Name: _____ _____ _____
   Last First Middle
2. Delaware License No: _____
3. Mailing Address: _____

   _____ _____ _____
   City State Zip
4. Office Phone: _____ 5. Email: _____

MALPRACTICE COMPLAINT

6. Plaintiff Name: _____ Age:_____ Sex:_____
7. Address of Record: _____
8. Date of Occurrence: _____
9. Place of Occurrence (office, hospital name & address): _____
10. What was your position in case (e.g., resident, primary physician)? _____
11. Who was the complaint filed against? ☐ Individual Doctor ☐ Group ☐ Hospital
12. Names of other defendant-doctors and/or hospitals: _____

    _____

DISPOSITION

13. What was the disposition? ☐ Verdict ☐ Settled
14. Final Disposition: _____ Date: _____
15. Civil Case No.: _____ 16. Attorney: _____
17. Total Amount Paid (if any): _____
18. Amount Attributable to You: _____
19. Insurance Company Covering You for this Incident:_____

You may attach a detailed explanation of the medical issues involved in the referenced litigation.

Signature: _____Date: _____